Senator Mike Gloor

Multi-payer patient-centered medical home stakeholder group
Meeting date: Tuesday, September 13, 2016, 10 a.m. to 12 noon CT
Meeting place: *Room 1524, State Capitol,* Lincoln, Nebraska
Senator Gloor's office phone: 402-471-2617
Conference Call Number: **(888) 820-1398;** Attendee Code: 1971560#

Attendees:
Senator Mike Gloor
Dr. Steve Lazoritz
Dr. Kevin Nohner, NMA and Uninet
Dr. Tony Sun, United HealthCare
Heather Leschinsky, NE Medicaid
Bryson Bartels, NDHHS
Robert Bell, NE Dept. of Insurance
Bruce Greenstein, The Compliance Team
Jina Ragland, NMA
Ann Larimer, Office of Rural Health
Amy Behnke, HCAN
Martha Striker, Region West Physicians Clinic
Erin Williams, RDN, Beatrice Hospital
Margaret Buck, Sen. Gloor's office
Dr. Bob Rauner, Healthy Lincoln
Dr. Don Darst
Dr. Ken Shaffer, Uninet
Dr. Dale Michels, SERPA ACO
Margaret Brockman, Office of Rural Health
Judy Martin, NDHHS
Liz Simon, NAFP
Steve Simmerman, The Compliance Team
Sue Medinger, Office of Rural Health
Deb Stoltenberg, Office of Rural Health
Elizabeth Hurst, NHA
Christine Moran, RDN, Beatrice Hospital
Kaitlin Reece, Sen. Crawford's office

Senator Gloor welcomed everyone and read the anti-trust statement.

Bruce Greenstein gave a brief recap of The Compliance Team and their PCMH accreditation, asking to be included in the variety of accreditations accepted by the Nebraska Participation Agreement. He explained that TCT standards and NCQA standards are virtually the same but the application process is different, with TCT working more in-person and personal interaction with clinics in addition to an online tool. Their experience is mostly in rural areas with small and medium sized providers. A recent study stated that only 6.7 % of solo practices have PCMH accreditation, only 19% of small practices have even considered it. Large 35.1%. They work more collaboratively with providers during the application process and verification. In Nebraska they have accredited more than 10 rural health clinics, 30 pharmacies and 44 DME providers.

Answering questions on the challenge of technology for rural clinics he offered no easy answer but offered telehealth and pieces of technology such as registries as a partial answer. He also answered a question on the possible advocacy role he saw for the stakeholder group. He pointed to policy harmonization, clarity around regulations and funding for telehealth equipment. Senator Gloor added that advocacy of this group could also be broader than the state in advocating for grant funding or participation in federal programs.

Senator Gloor stated the TCT standard would be included in the re-write of the Participation Agreement for 2017 unless stakeholders in the meeting or afterward voiced opposition to it.

Amy Behnke, Executive Director of HCAN (Health Care Association of Nebraska), presented information on demographics of patients seen in the FQHCs in Nebraska and their progress and goals for PCMH accreditation. Slide presentation attached. Amy was asked if the success of the FQHCs have been correlated to being a PCMH and if they've calculated a return on investment. Her answer was that they have not deliberately tied their results to being PCMH accredited but when they talk about what works in the centers it is definitely the practice of the PCMH requirements. They are requested by the federal government to have a PCMH coach on staff through the HCAN. They do not calculate ROI but it would be a good calculation to make.

Dr. Bob Rauner presented a report with new Medicare ACO quality improvement statistics and rankings. Report attached. He suggested that Nebraska could find a way to track these measures statewide to measure outcomes. However, it would take all payers and the state collaborating together. Dr. Rauner spoke of problems with attribution methods in the MSSP that generally only pick up about 70% of what the physicians think are their Medicare patients. However, they are looking at a way for the patient to designate their primary care physician.

Margaret Buck announced that the PCMH information housed on Senator Gloor's webpage will be available at the office of rural health after Senator Gloor is termed out.

Senator Gloor began a discussion of a 2017 Participation Agreement by asking if the stakeholders still think it is needed and if the issue of a nurse practitioner led clinic is still of concern. He reviewed the discussion from last year that changed the Agreement from a 2-year to a 1-year Agreement, regarding whether the definition of PCMH should remain physician-led or if it should be "primary care-led" that would include nurse practitioners. He invited discussion.

Dr. Lazoritz pointed out that the two of the three current managed care participants will no longer be involved in managed care in 2017 and that getting reports from those companies will be difficult if not impossible due to staff leaving. He suggested to wait on the new Agreement until the new MCOs are up and running in order to be able to include the new companies.

Senator Gloor suggested an extension of the current Agreement in order to provide anti-trust protection and asked about timeframes on the new companies.

Dr. Lazoritz and Heather Leschinsky, Nebraska Medicaid, discussed the Medicaid quality committee and possible measures that might be used. Dr. Rauner suggested that until we know the future of the stakeholder collaborative in either a large payer or a state agency or another enitity. Dr. Nohner, Uninet ACO, stated that the group needs a place to convene even if there is no leadership from payers or the State. He wants to continue the Agreement.

Senator Gloor introduced a letter from August 15 from Courtney Phillips, CEO of NDHHS. Senator Gloor introduced legislation that would have given responsibility for the stakeholder group to NDHHS. LB 333 and 549 asked for some State leadership on health care issues but conversations with the Governor indicated a request for time to allow a non-legislative solution. The letter from Courtney Phillips offers the place to allow this collaborative to convene through the Office of Rural Health and their staff would provide administrative support. That leaves the

leadership question unanswered. Senator Kolterman is happy to provide legislative participation moving forward. However, he does not have the clinical background and history with PCMH so another form of leadership still needs to be found as a long term solution. Senator Gloor reported that he had conducted a conference call of the physicians on the original Medicaid pilot program advisory council to get their feedback. He stated that the collaborative or committee will have trouble remaining viable without a leadership entity.

Dr. Rauner talked about how other states have formed long-term solutions but stated that those forces have not come together yet in Nebraska. Dr. Lazoritz stated he feels that this group has worked because of our inclusivity, although the disruption of the Medicaid contract has reduced the attendance temporarily.

Sue Medinger, Division of Public Health, stated that the Office of Rural Health will provide the room and administrative support but the leadership did need to come from outside NDHHS.

The question of the Department of Insurance role in the Stakeholder group was raised. Senator Gloor stated that as the former Chair of Banking and Insurance Committee in the Legislature, he felt that the Department of Insurance was not the appropriate place for leadership of this issue. Robert Bell, of the Nebraska Department of Insurance, agreed with that view.

Dr. Ken Shaffer, Kearney, offered that the stakeholder group needs to think broader than PCMH to more forms of clinical transformation. He thinks the flexibility of keeping the Agreement in the legislative arena allows for open discussion and that we just need a forum for continuing discussion.

No further comments were forthcoming. Senator Gloor wrapped up the meeting by stating that we will have one or possible two more meetings this year to finalize the 2017 Agreement since the current Agreement ends December 31, 2016. Those meeting dates will be determined and announced via email. Meeting adjourned.

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Nebraska's Federally Qualified Health Centers

PCMH Snapshot

Amy R. Behnke, CEO

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FQHC Snapshot

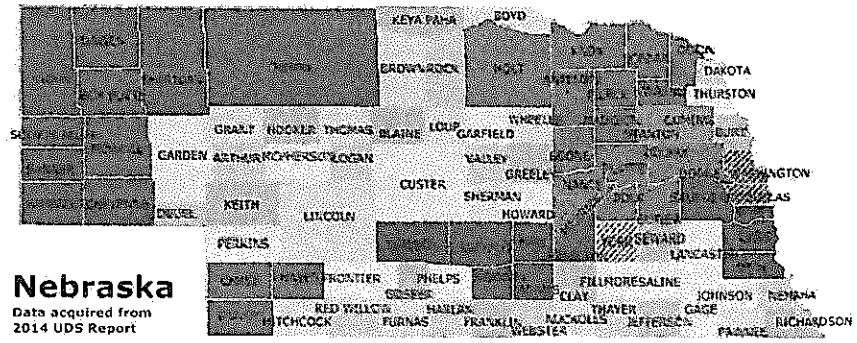
Health Center Association of Nebraska

- State Primary Care Association established in 2011
- Funded primarily through a Cooperative Agreement through the U.S. Department of Health and Human Services' Health Resources and Services Administration
- Primary Activities of the Association:
  - Educate Nebraskans on the mission, services, and value of community health centers
  - Partner with communities to expand services and meet the needs of the medically underserved
  - Promote healthcare workforce development, recruitment, and retention
  - Network with organizations at the regional and national level for healthcare excellence and equity
  - Provide technical assistance and training to Nebraska's health centers

Health Centers' Impact

- Our Association is:
  - 7 Health Centers
  - 46 delivery sites
  - Nearly 600 Center employees
  - 2 Associate member Centers in Council Bluffs and Sioux City
- Who We Served in 2015:
  - 76,504 patients with 293,489 visits
  - 92% are below 200% of the federal poverty level
  - 70% are of a racial or ethnic minority
  - 47% are uninsured
- Our Estimated Economic Impact:
  - Contribute over $108 million to Nebraska's economy
  - Save Nebraska's health care system $88 million on an annual basis

Health Center Service Areas



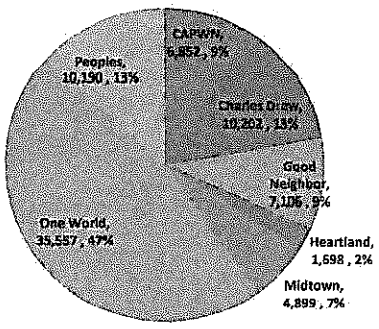
Nebraska

Data acquired from 2014 UDS Report

- Charles Drew Health Center
- Community Action Partnership of Western Nebraska
- Good Neighbor Community Health Center
- Heartland Health Center
- Midtown Health Center
- OneWorld Community Health Centers, Inc.
- People's Health Center

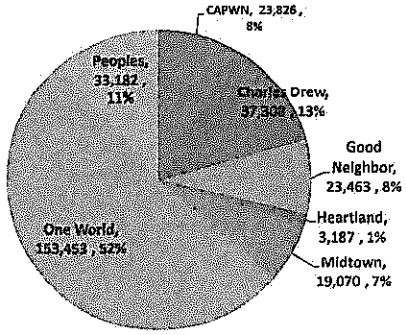
Patients & Visits Overview

2015 Patients

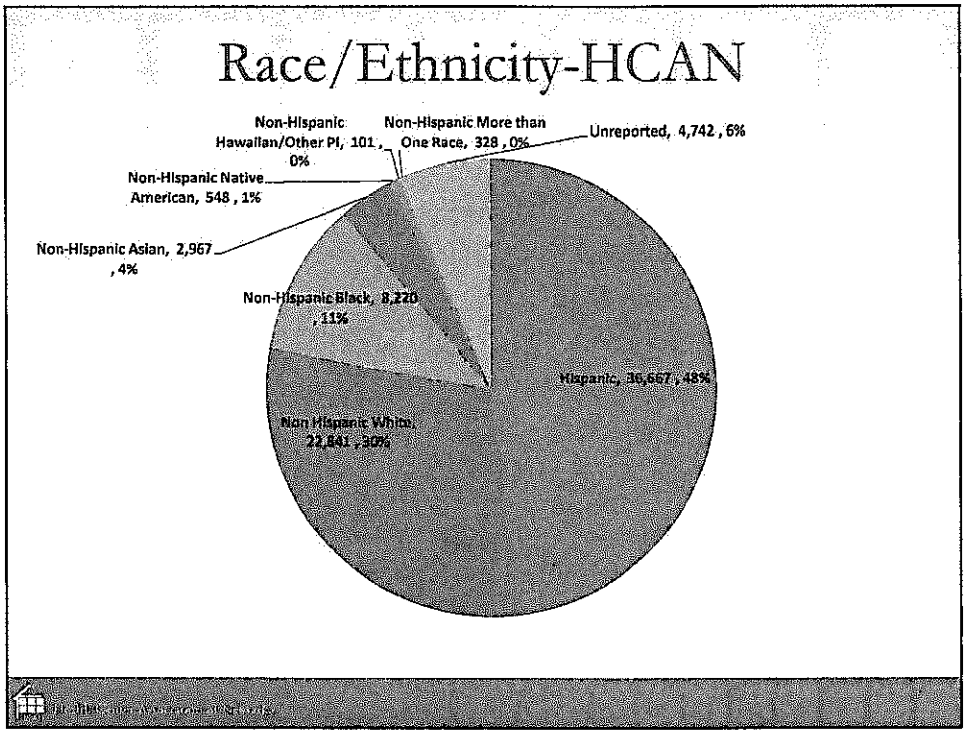


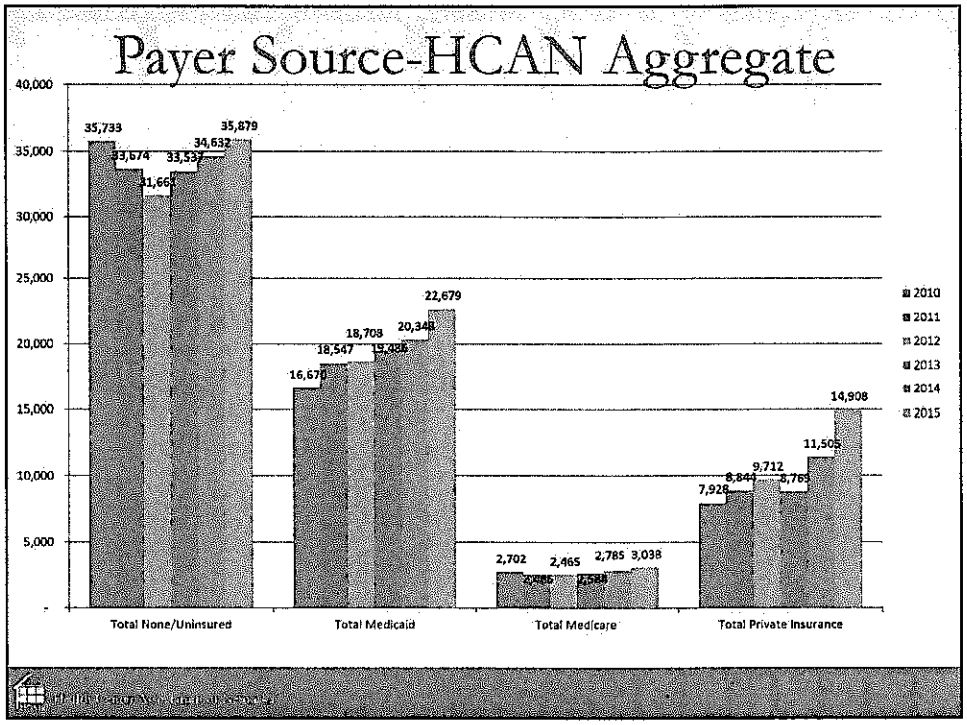
- 76,504 Total Patients
- Growth of 7,198 patients over 2014 (10.4%)

2015 Visits



- 293,489 Total Visits
- Growth of 20,623 Visits over 2014 (8.3%)


Race/Ethnicity-HCAN
Non-Hispanic Hawaiian/Other PI, 101, 0%
Non-Hispanic More than One Race, 328, 0%
Unreported, 4,742, 6%
Non-Hispanic Native American, 548, 1%
Non-Hispanic Asian, 2,967, 4%
Non-Hispanic Black, 8,220, 11%
Hispanic, 36,667, 48%
Non Hispanic White, 22,841, 30%


Payer Source-HCAN Aggregate
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
-
35,733
33,674
31,664
33,537
34,632
35,879
16,670
18,547
18,708
19,386
20,348
22,679
2,702
2,465
2,785
3,038
7,928
8,841
9,712
8,765
11,503
14,908
Total None/Uninsured
Total Medicaid
Total Medicare
Total Private Insurance
2010
2011
2012
2013
2014
2015

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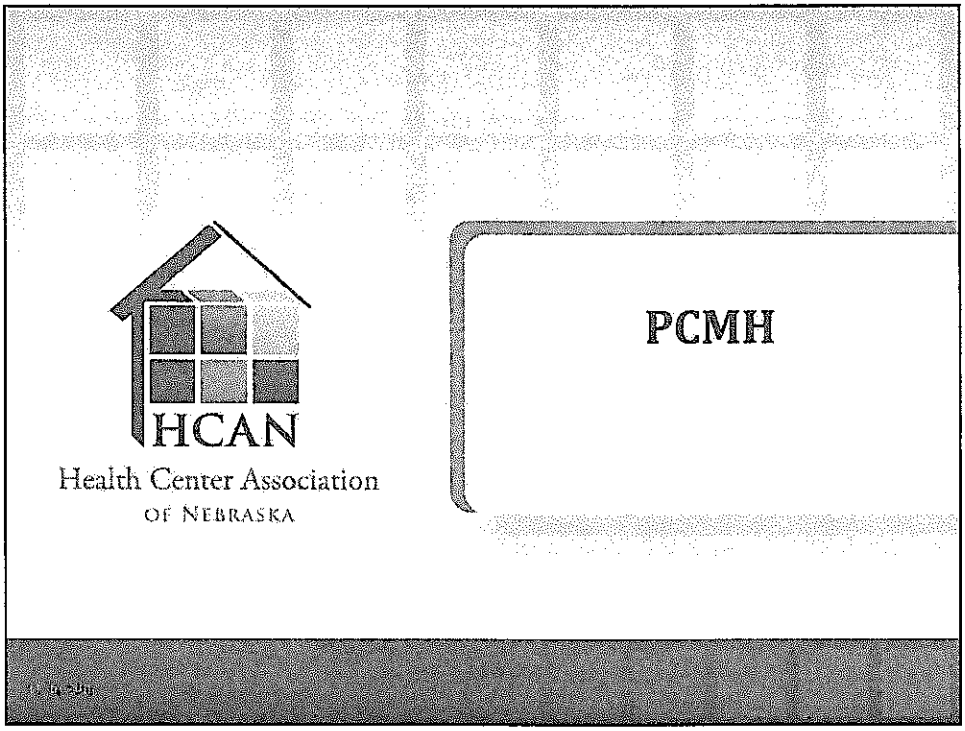
FQHC Quality Measures

2015 Quality Rankings*

- Overall, Nebraska FQHCs have the 5th best quality ranking in the nation
- 1st in the nation for Depression Screening and HIV Connection to Care
- Top 5 in the nation
  - Dental sealants (2nd)
  - Adolescent weight screening (3rd)
  - Tobacco screening and cessation (4th)
  - Blood pressure control measures (5th)
- Significant movement in Diabetes Control and Coronary Artery Disease measures
- Nebraska FQHCs received over $600,000 in Quality Improvement Awards in August 2016

*Statistics derived from state rankings of Uniform Data System (UDS) data for 2015



Current PCMH Status

- 5 of Nebraska's 7 FQHCs have achieved PCMH recognition
  - 2 Joint Commission
  - 3 NCQA
- 1 FQHC actively working toward applying for PCMH recognition
- 1 FQHC is currently on hold pending administrative transitions
- HCAN Goal: 100% of our FQHCs will achieve PMCH recognition by 2018

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Looking Ahead

Future Strategies

- Statewide Patient Satisfaction Survey
  - Trend analysis at the center level and statewide
  - Benchmarking statewide and at the national level
- Continued work on Team Based Care
  - Utilize the team effectively in a PCMH practice
  - Engage staff and providers
  - Create a vision and movement forward
- Deployment of PCMH concepts
  - Comprehensive care management
  - Access to care and information
  - Effective use of technology
  - Continued patient engagement

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QUESTIONS

Nebraska Medicare Shared Savings Program ACO Quality Summary 2015

Bob Rauner, MD, MPH, FAAFP
Legislative Chair, Nebraska Academy of Family Physicians

Background:

Medicare has publicly released the 2015 results for all Medicare Shared Savings Program ACOs. Data is available here - https://data.cms.gov/browse?category=ACO&utf8=%E2%9C%93&sortBy=newest. The full quality results of Nebraska's 3 Medicare Shared Savings Program ACOs who reported this year (Alegent Health Partners, Midwest Health Coalition ACO and SERPA ACO) are shown on page 2. The other 2 ACOs (Think ACO, LLC based in Omaha and CHI Health Partners that spans Nebraska City, Lincoln, Grand Island and Kearney) are in their first year, so their first reporting period will be early next year with their quality results publicly available along with the other 3 in August 2017. I am aware of 3 other organizations in Nebraska that applied for January 1, 2017 start dates which would potentially raise the total to 8 Nebraska MSSP ACOs in 2017.

The 34 quality measures are grouped into 4 major categories/sources of data:

1. Patient Satisfaction (ACO 1-7, 34) – Data Source: Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey
2. Utilization (ACO 8-10, 35-38) – Data Source: Medicare claims data
3. Electronic Health Record Meaningful Use (ACO 11) – Data Source: EHR Incentive Program
4. Clinical Quality Measures (17 Measures) – Data Source: combination of Medicare claims data and physician medical records

Summary:

1. Overall quality score:
    a. Alegent/UniNet 94.3%
    b. MIPPA 84.5%.
    c. SERPA ACO 92.4%
2. Leading Nebraska ACO in each of the 34 quality measures:
    a. Alegent Health Partners - 6
    b. Midwest Health Coalition - 7
    c. SERPA ACO - 21

Context for Multi-Payer Patient-Centered Medical Stakeholder Group:

The past joint voluntary Nebraska PCMH agreements have used Medicare Shared Savings Program (MSSP) quality measure specifications for its list of adult measures. It is highly likely that the Merit-Based Incentive Payment System quality measures for the Medicare and CHIP Reauthorization Act that will adjust future physician Medicare payments will also draw from these measures. These provide a common method of comparison for Nebraska PCMH initiatives. Because all 392 MSSP ACOs in the United States use these quality specifications, we should consider using these measures for future Nebraska initiatives to measure quality in adult populations. These are now 5 MSSP ACOs based in Nebraska and possibly 3 more starting January 1, 2017, so these measures will likely be in use by the majority of Nebraska clinics in 2017.

	Alegent Health Partners, LLC	Midwest Health Coalition ACO	SERPA-ACO	National Average
ACO Start Date	1/1/2013	1/1/2014	1/1/2013	
Number of Assigned Medicare Beneficiaries	28,172	11,047	15,132	18,547
Quality Score	94.29%	84.52%	92.35%	91.44%
ACO-1: Getting Timely Care	84.63	84.98	78.98	80.11
ACO-2: Provider Communication	92.86	93.62	93.09	92.41
ACO-3: Patient's Rating of Provider	92.75	92.84	92.64	91.69
ACO-4: Access to Specialists	83.72	85.73	87.82	83.50
ACO-5: Health Promotion and Education	57.82	53.94	55.57	58.98
ACO-6: Shared Decision Making	78.79	73.28	74.37	74.80
ACO-7: Health Status/Functional Status	73.49	72.50	74.62	71.92
ACO-34: Stewardship of Patient Resources	29.54	35.07	29.47	27.35
ACO-8: Risk Standized Readmissions	*14.80*	*14.78*	*14.45*	*14.86*
ACO-9: Asthma/COPD Admissions	*1.55*	*1.44*	*1.29*	*1.11*
ACO-10: Heart Failure Admissions	*0.94*	*1.01*	*0.72*	*1.04*
ACO-35: Skilled Nursing 30 Day Readmit	*17.23*	*18.42*	*18.33*	*18.06*
ACO-36: Diabetes Unplanned Admissions	*60.33*	*60.97*	*50.09*	*54.57*
ACO-37: Heart Failure Unplanned Admissions	*86.03*	*82.45*	*72.43*	*76.96*
ACO-38: Multiple Chronic Disease Readmissions	*73.88*	*72.29*	*62.46*	*62.92*
ACO-11: Meaningful Use	86.90	42.86	98.18	80.50
ACO-39: Medications Documented	97.93	92.33	90.76	84.07
ACO-13: Fall Risk Screening	44.79	42.36	74.92	56.59
ACO-14: Influenza Vaccination	74.43	68.63	84.44	62.02
ACO-15: Pneumonia Vaccination	76.77	78.25	88.64	63.78
ACO-16: Body Mass Index Screening	59.44	71.45	61.30	71.17
ACO-17: Tobacco Screening/Counseling	95.07	89.11	93.77	90.25
ACO-18: Depression Screening	45.86	21.83	74.53	45.33
ACO-19: Colorectal Cancer Screening	54.37	62.21	71.51	60.04
ACO-20: Breast Cancer Screening	61.64	66.78	74.57	65.65
ACO-21: Blood Pressure Screening	37.07	82.38	49.11	70.04
ACO- 40: Depression Remission	6.67	0.00	8.00	6.13
Diabetes Composite	48.00	47.06	57.94	35.45
ACO-27: Diabetes A1c Poor Control	*12.67*	*15.97*	*10.14*	*20.42*
ACO-41: Diabetic Eye Exams	52.00	54.29	62.67	41.14
ACO-28: Blood Pressure Control	76.09	67.13	76.16	69.61
ACO-30: Ischemic Vascular Disease Aspirin Use	91.52	93.63	86.61	83.81
ACO-31: Heart Failure Beta Blocker Therapy	95.45	91.35	85.64	87.20
ACO-33: Coronary Artery Disease ACE/ARB Use	82.27	71.43	84.58	77.74

*Note that for Italicized measures above, a lower number is better.